RESIDENT'S HEALTH STATUS - SUMMARY

DISTRICT OFFICE STAMP

RESIDENT'S NAME	DEPARTMENT USE ONLY
FACILITY NAME	FACILITY NUMBER

A. HEALTH CONDITIONS GENERALLY ALLOWED

CHECK ALL THAT APPLY:

1. Oxygen Administration (self-care) ☐
2. IPPB Therapy (self-care) ☐
3. Colostomy or Ileostomy (self-care) ☐
4. Enema, Suppository and/or Fecal Impaction Removal (self-care or done by ASP) ☐
5. Indwelling Catheter (self-care with assistance of ASP) ☐
6. Managed Incontinence (self-care or clean and dry) ☐
7. Contractures-Nondisabling (self-care) ☐
8. Diabetic (self-care or care by ASP) ☐
9. Injections - Intramuscular, Intradermal or Subcutaneous Only (administered by self or ASP) ☐
10. Protective Supervision-Mild ☐
11. PRN Medications ☐
12. Temporarily bedridden for 14 days or less ☐
13. Other, Specify ☐

B. CONDITIONS REQUIRING EXCEPTION/APPROVAL

CHECK ALL THAT APPLY:

1. Oxygen Administration (administered by ASP) ☐
2. IPPB Therapy (administered by ASP) ☐
3. Colostomy or Ileostomy (assisted by ASP) ☐
   a. Bag change by staff ☐
4. Indwelling catheter - Bag emptying by staff ☐
5. Contractures - Nondisabling (care by ASP) ☐
6. Healing wound (care by ASP) ☐
7. Dermal ulcers (Stage I & II) ☐
8. Temporarily bedridden for more than 14 days ☐
9. Protective Supervision-Severe ☐
10. Liquid Oxygen ☐
11. Postural Supports ☐
12. Any other health condition you question, including an allowable condition. Describe. ☐

C. PROHIBITED HEALTH CONDITIONS

CHECK ALL THAT APPLY:

1. Oxygen Tent ☐
2. Oxygen Therapy (Other than as specified in A and B) ☐
3. IPPB Therapy (other than self-care or ASP) ☐
4. Colostomy/Ileostomy (other than as specified in A and B) ☐
5. Enemas and/or suppositories (other than self-care or ASP) ☐
6. Manual fecal impaction removal (other than ASP) ☐
7. Catheter (other than as specified in A and B) ☐
8. Unmanaged incontinence ☐
9. Disabling contractures ☐
10. Diabetic with metabolic instability ☐
11. Injections (other than A-9) ☐
12. IVs ☐
13. Protective supervision-combative, needs restraint ☐
14. Gastrostomy ☐
15. Wound requiring irrigation ☐
16. Dermal ulcers above Stage II ☐
17. Permanently bedridden ☐
18. Total care ☐
19. Active communicable disease ☐
20. Serious infection ☐
21. Tracheostomy care ☐
22. Naso-gastric tube ☐
23. Any condition requiring 24-hour skilled nursing care ☐
24. Any condition requiring inpatient care in a licensed health facility ☐
25. Other, specify. ☐

ABBREVIATION KEY: ASP = Appropriately Skilled Professional

INSTRUCTIONS:

Complete a RESIDENT'S HEALTH STATUS SUMMARY form for each resident with an identified health service need. Check answer boxes for each condition that applies.

If the resident has identified health service needs that fall into either the "Conditions Requiring Exception/Approval" or "Prohibited Health Conditions" categories, complete the attached REVIEW OF RESIDENT'S HEALTH STATUS form and page 2 of RESIDENT'S HEALTH STATUS SUMMARY.

If the only health condition identified is Managed Incontinence and you determine that this facility can meet the needs of this resident by meeting the care standards in regulations, complete sections M, N and O of the REVIEW OF RESIDENT'S HEALTH STATUS form.

If the only health service need identified falls within the "Health Conditions Generally Allowed" category (and is other than Managed Incontinence), and you determine that this facility can meet the needs of this resident by meeting the care standards in regulations, check the box below and sign at the bottom of this page.

☐ APPROVED CONDITION

NAME OF LPA COMPLETING FORM	PHONE NUMBER	DATE

☐ DISTRICT MANAGER APPROVAL/EXCEPTION REQUIRED

RECOMMENDATION OF LPA:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

RECOMMENDATION OF LPS:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

DOCUMENTATION OF NURSE CONSULTANT CONTACT, IF NEEDED.
RECOMMENDATION:

☐ APPROVE

☐ DENY

NAME OF NURSE CONSULTANT | DATE OF CONTACT

DISTRICT MANAGER DECISION:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

COMMENTS:

☐ PROHIBITED CONDITIONS

*IF PROHIBITED CONDITION WAS CITED **PRIOR** TO DISTRICT MANAGER REVIEW:*

SIGNATURE OF LPA | DATE

APPEALED ☐ YES ☐ NO

IF APPEALED:

RECOMMENDATION OF LPS:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

NURSE CONSULTANT INPUT, IF NEEDED:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

DISTRICT MANAGER RECOMMENDATION:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

REGIONAL MANAGER DECISION, IF NECESSARY:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

COMMENTS:

EXCEPTION REQUESTED ☐ YES ☐ NO

IF YES:

RECOMMENDATION OF LPA:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

RECOMMENDATION OF LPS:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

NURSE CONSULTANT INPUT, IF NEEDED:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

DISTRICT MANAGER RECOMMENDATION:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

REGIONAL MANAGER DECISION, IF NECESSARY:

☐ APPROVE

☐ DENY

SIGNATURE | DATE

CONDITIONS OF EXCEPTION:

REVIEW OF RESIDENT'S HEALTH STATUS

INSTRUCTION: COMPLETE ALL ITEMS BELOW. ATTACH ADDITIONAL PAGES, IF NECESSARY.

ABBREVIATION KEY

ASP = Appropriately Skilled Professional
[E] = Allowed only by exception
[P] = Prohibited

RESIDENT'S NAME		
BIRTHDATE	SEX ☐ MALE ☐ FEMALE	
ADMISSION DATE	SSI/SSP? ☐ YES ☐ NO	

FACILITY NAME	FACILITY NUMBER	FACILITY TELEPHONE NUMBER
		( )
PHYSICIAN'S NAME		PHYSICIAN'S TELEPHONE NUMBER ( )

A. MEDICAL DIAGNOSIS(ES)

List current medications, including dosage, strength etc.

1. _____
2. _____
3. _____
4. _____
5. _____

C. DATE OF MOST RECENT PHYSICAL ASSESSMENT

MONTH ____ DAY ____ YEAR ____

D. DATE OF MOST RECENT MEDICAL VISIT

MONTH ____ DAY ____ YEAR ____

E. MENTAL AND BEHAVIORAL STATUS

CHECK ALL THAT APPLY:

1. Alert ☐
2. Disoriented ☐
3. Wanderer ☐
4. Disruptive ☐
5. Screamer ☐
6. Physically combative ☐
7. Lethargic ☐
8. Confused ☐
9. Agitated ☐
10. Self-abusive ☐
11. Other, specify _____ ☐

F. COMMUNICATION

CHECK ALL THAT APPLY:

1. Able to communicate:
   a. Verbally ☐
   b. Other, specify_____ ☐
   _____
2. Unable to make needs known [P] ☐

G. ACTIVITIES OF DAILY LIVING (ADLs)

KEY: I - Independent
A - Assistance required
D - Dependent

Check I, A, or D:	I	A	D
1. Bathing	☐	☐	☐
2. Dressing	☐	☐	☐
3. Grooming	☐	☐	☐
4. Toileting	☐	☐	☐
5. Eating	☐	☐	☐

Dependent in all 5 ADLs = Total Care [P] ☐

H. MOBILITY

	YES	NO
1. Able to walk unassisted If no:	☐	☐

a. Type of assistance needed,
   1. Caregiver ☐
   2. Wheelchair ☐
   3. Braces ☐
   4. Walker ☐
   5. Crutches ☐
   6. Grab bar ☐
   7. Other, specify _____ ☐
   _____

b. Reasons for inability to walk unassisted
   1. Paralysis ☐
   2. Amputation ☐
   3. Swollen joint/pain ☐
   4. Disabling contractures [P] ☐
   5. Severe dementia/ confusion [P] ☐
   6. Generally frail ☐
   7. Other, specify _____ ☐
   _____

c. Extremity(ies) involved
   _____

H. MOBILITY (Continued)

	YES	NO
2. Temporarily bedridden* for 14 days or less	☐	☐
3. Temporarily bedridden* for more than 14 days [E] Specify date bedridden status is expected to end_____	☐	☐
4. Permanently bedridden* [P]	☐	☐

*Bedridden = Unable to leave a building unassisted under emergency conditions and requires assistance in turning and repositioning in bed.

I. VISION

	YES	NO
1. Visual Impairment If yes:	☐	☐
a. Blind	☐	
b. Corrected with lens	☐	
c. Uncorrected	☐	
d. Other, specify _____	☐	

J. HEARING

	YES	NO
1. Hearing impairment If yes:	☐	☐
a. Deaf	☐	
b. Hears your voice	☐	
c. Hearing aid(s)	☐	
d. Other, specify _____	☐	

K. BREATHING (RESPIRATORY)

	YES	NO
1. Problems with Breathing If yes:	☐	☐
2. Inhalation Therapy:	☐	☐
a. Oxygen	☐	
1. Concentrator	☐	
2. Tanks (Liquid Oxygen = [E])	☐	
3. Tent [P]	☐	
4. Self-care	☐	
5. Care by ASP [E]	☐	
6. Other, specify _____	☐	
_____		
b. IPPB	☐	
1. Self-care	☐	
2. Care by ASP [E]	☐	
3. Other, specify _____	☐	
_____		
3. Tracheostomy [P]	☐	
4. Suctioning Equipment [P]	☐	
5. Other, specify _____	☐	
_____		

L. NUTRITION

	YES	NO
1. Resident has eating/dietary problems	☐	☐
If yes, check all that apply:		
a. Special diet	☐	
b. Feeds self	☐	
c. Feeds self with assistive device	☐	
d. Needs assistance with eating	☐	
e. Must be fed (cannot feed self)	☐	
f. Extremely underweight	☐	
g. Extremely obese	☐	
h. Tube feeding [P]	☐	

M. BOWEL

	YES	NO
1. Incontinent	☐	☐
If yes:		
a. Managed	☐	
b. Unmanaged [P]	☐	
4. Colostomy/Ileostomy	☐	☐
If yes, check all that apply:		
a. Self-care	☐	
b. Care by ASP [E]	☐	
c. Staff empty bag [E]	☐	
5. Manual fecal impaction removal	☐	☐
If yes, check all that apply:		
a. Current need	☐	
b. Repeated need	☐	
c. Performed by ASP	☐	
d. Self-care	☐	
e. Performed by other [P]	☐	
6. Enema	☐	☐
a. Performed by ASP	☐	
b. Self-care	☐	
c. Performed by other [P]	☐	
7. Suppository	☐	☐
a. Performed by ASP	☐	
b. Self-care	☐	
c. Performed by other [P]	☐	

N. BLADDER

	YES	NO
1. Incontinent	☐	☐
If yes:		
a. Managed	☐	
b. Unmanaged [P]	☐	
2. Catheter	☐	☐
If yes, check all that apply:		
a. Indwelling	☐	
b. Other [P]	☐	
c. Self-care, except insertion and irrigation.	☐	
d. Care by ASP	☐	
e. Staff change bag [E]	☐	

O. PRESSURE SORES (DERMAL ULCERS)

	YES	NO
1. Does resident have pressure sores?	☐	☐
If yes, are they:		
a. Stage I or II {E}	☐	
b. Stage III or IV [P]	☐	
2. Location(s) on body/describe:		
_____		
_____		
3. Has condition been diagnosed by a physician?	☐	☐
4. Is care provided by an ASP? [E]	☐	☐

P. SPECIAL NEEDS/CONDITIONS

	YES	NO
1. Open draining wound [P]	☐	☐
2. Wound requiring irrigation [P]	☐	☐
3. Diabetic care	☐	☐
If yes, check all that apply:		
a. Special diet	☐	☐
b. Medication	☐	☐
Check all that apply:		
1. Oral	☐	
2. Injection - self	☐	
3. Injection - ASP	☐	
4. Injection - Other [P]	☐	

P. SPECIAL NEEDS (Continued)

	YES	NO
c. Tests - Diabetic	☐	☐
If yes, check all that apply:		
1. Urine	☐	
2. Blood	☐	
3. Self - testing	☐	
4. ASP - testing [P]	☐	
5. Other - testing [P]	☐	
4. History of seizures	☐	☐
If yes, check all that apply:		
a. On medication	☐	
b. Under ASP care	☐	
c. Date of last seizure _____		
5. Injections	☐	☐
If yes, specify medication _____		
_____		
_____		
_____		
If yes, check all that apply:		
a. Injection - Self Care	☐	
b. Injection - ASP	☐	
c. Injection - Other [P]	☐	
6. IVs[P]	☐	☐
7. Allergies	☐	☐
If yes, specify _____		
_____		
_____		
_____		
_____		
8. Postural Supports [E]	☐	☐
9. Behavioral Restraints [P]	☐	☐
(Includes locked doors, buildings and perimeters)		
If yes, specify _____		
_____		
_____		

Q. GENERAL APPEARANCE, COMMENTS, OBSERVATIONS

LICENSING PROGRAM ANALYST	DATE